"LIVING WELL"—*An Integrative Approach to Wellness with MS*

Member Application

Name: ____ Date:______________

Address:____

City: _________________________________State: ____ Zip: _______________

Phone: *Home*____________ *Work*______________ *Cell* ___________________

E-mail address:_____________________________Fax: ___________________

Gender: ❑ Male ❑ Female Handedness: ❑ Left ❑ Right ❑ Both

Date of Birth:___/___/______

Emergency Contact:____
(name/relationship) (phone #)

SOCIAL INFORMATION

Place of Birth:__________________________

Do you use tobacco? ❑ Yes ❑ No
If yes, indicate type, amount and for how long:_______________________

Do you consume alcohol? ❑ Yes ❑ No
If yes, indicate type, amount and for how long:_______________________

Total years of Formal Education:
❑ Grade School (1-8) ❑ High School (9-12) ❑ College (13-16)
❑ Masters (17-18) ❑ Doctorate (19-20)

Marital Status:
❑ Single (never married) ❑ Married ❑ Domestic Partner
❑ Separated ❑ Divorced ❑ Widowed
❑ Other: _________________________

Who lives with you at the present time?
❑ Spouse ❑ Children ❑ Parent(s)
❑ Brothers +/or Sisters ❑ Other Relatives ❑ Friends
❑ Live Alone ❑ Other:______________________________

EMPLOYMENT INFORMATION

Have you ever held a job? ❑ Yes ❑ No

What is your current employment status?

❑ Employed full-time	❑ Unemployed	❑ Retired
❑ Employed part-time	❑ Unemployed due to MS	❑ Retired due to MS
❑ Employed part-time due to MS		❑ Student
❑ Other:______________________________		

If employed, what kind of work do you do?__________________________

Describe any problems your MS is causing in terms of your work or school:

____

____

MEDICAL INFORMATION

Insurance Info:	❑ PPO/POS _____________	❑ HMO_______________
	❑ Medicare	❑ Medi-Cal
	❑ Other_________________	❑ None

Primary Care Physician:____

Address:____

City: _________________________________State: ____ Zip: _______________

Phone:________________________________FAX: ________________________

Neurologist:____

Address:____

City: _________________________________State: ____ Zip: _______________

Phone:________________________________FAX: ________________________

Date of onset of Initial Symptoms of MS:______________

Date of MS Diagnosis:______________

The following is a list of symptoms some people with MS have experienced. Not everyone who has MS experiences these symptoms so please do not read anything into this list. Please check off only the symptoms you are **currently** experiencing:

- ❑ Visual Changes
- ❑ Changes in Sensation
- ❑ Pain
- ❑ Tremors
- ❑ Spasticity (muscle stiffness)
- ❑ Impaired Coordination
- ❑ Muscle Weakness
- ❑ Impaired Balance/Dizziness
- ❑ Bladder Problems
- ❑ Bowel Problems
- ❑ Changes in Sexual Function
- ❑ Fatigue
- ❑ Heat Sensitivity
- ❑ Changes in Speech/Swallowing
- ❑ Memory or other Cognitive Changes
- ❑ Falls in Last 6 Months
- ❑ Emotional Changes (feelings of sadness, hopelessness, changes in appetite/sleep) (describe):____
- ❑ Other (describe):____

List the 3 areas that are the most challenging to you in respect to MS (list the most challenging area first):

1.
2.
3.

List any mobility devices you currently use:______________________________

Do you have any other medical problems? ❑ Yes ❑ No

If yes, check all that apply:

- ❑ Abnormal Bleeding
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Osteoporosis
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Other ______________________
- ❑ Heart Disease: ❑ Heart Attack ❑ Chest Pain ❑ Irregular Heart Beats ❑ Fainting

Hospitalizations, Operations and Injuries including broken bones (include dates):

Allergies: ❑None ❑Drug ❑Food ❑Iodine ❑Latex ❑Other______________

Describe: ____

____

Are you currently taking any of the **MS treatment** medications? ❑ Yes ❑ No

If yes, please check: ❑ Aubagio ❑ Avonex ❑ Betaseron/Extavia
❑ Copaxone/Glatopa ❑ Gilenya ❑ Ocrevus ❑ Plegridy ❑ Rebif ❑ Tecfidera
❑Tysabri ❑ Zinbryta ❑ Other:___________

Current Prescribed Medications:

Name	Dosage	How Often?

Over the Counter Medications, Vitamins, Herbs and Supplements:

Name	Dosage	How Often?

EXERCISE HISTORY

Do you currently exercise? ❑ Yes ❑ No

If yes, please indicate your current exercise program:

	Distance/Duration	Frequency per Week
❑ Walking	________________	__________________
❑ Treadmill	________________	__________________
❑ Bicycling	________________	__________________
❑ Stationary Bicycle	________________	__________________
❑ Swimming	________________	__________________
❑ Yoga	________________	__________________
❑ Tai Chi	________________	__________________
❑ Feldenkrais	________________	__________________
❑ Pilates	________________	__________________
❑ Posture/Balance Exercises	__________	__________________
❑ Stretching: ❑ Upper Body ❑ Lower Body		__________________
❑ Weights: ❑ Upper Body ❑ Lower Body		__________________

❑ Other: ____

If you do not currently exercise, have you exercised in the past? ❑ Yes ❑ No

If yes:

What did you do for exercise?_______________________________________

When did you stop exercising?_______________________________________

Why did you stop exercising? _______________________________________

How would you rate your overall knowledge about MS:

❑ Poor ❑ Fair ❑ Good ❑ Very Good ❑ Excellent

How would you rate your overall level of wellness:

❑ Poor ❑ Fair ❑ Good ❑ Very Good ❑ Excellent

Why did you choose to come to this program?

Please state one (or more) personal goal(s) that you would like to accomplish in this program.

1.

2.

3.

Please FAX application to:
Marilyn Hilton MS Achievement Center at (310) 267-4075,

or

MAIL to:
Executive Director
Marilyn Hilton MS Achievement Center at UCLA,
1000 Veteran Ave., Ste. 11-62, Box 714722
Los Angeles, CA 90095-7147